**Date of Filing:** 06.06.2022

**Date of Order:** 04.07.2024

**BEFORE THE DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION, COLLECTORATE CAMPUS, COIMBATORE-18**

**PRESENT:** Thiru R.THANGAVEL, B.Sc., B.L., President
Thiru P.MARIMUTHU, M.A.M.L., Member
Tmt G.SUGUNA, B.A.B.L., Member

# C.C.No.152/2022
## Thursday, the 04th day of July, 2024

Saipreman,S/o.Damodharan,
D2, TNEB Quarters,
Mathampatty,Coimbatore – 641 010. ….. Complainant

... Vs …

1. Dr.R.Tamil Selvan, Medical Officer,
   M/s. Kalpana Medical Centre(P)Ltd.,
   Mettupalayam road, Kavundampalayam,
   Coimbatore – 641 030.

2. Dr.Antony, Medical Officer, M/s. Kalpana Medical Centre(P)Ltd.,
   Mettupalayam road, Kavundampalayam,
   Coimbatore – 641 030.

3. M/s.Kalpana Medical Centre(P)Ltd., Rep by its Managing Director,
   Dr.Balachander MBBS, M.S.Ortho.,
   Mettupalayam road, Kavundampalayam,
   Coimbatore – 641 030.

4. Dr.Arun Kumar, M.D.S.Maruthi Dental & Face,
   Surgical Centre, 511, NSR Road,
   Saibaba Colony,
   Coimbatore – 641 038.

5. M/s. Swaasam blood blank, Rep by Dr.Karthick Kumar,
   No.9/3, Sakthi Estate, 3rd Street,
   M.G.Road, Avarampalayam,
   Coimbatore - 6 …..Opposite Parties

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This case having come on for final hearing before us on 20/06/2024 in the presence of Thiru. S. Balamurugan Advocate for complainant and Thiru. M. Sanjayan, Advocate for 1st opposite party and Thiru. S. Shivashankar, Advocate for 2nd and 3rd opposite parties and Thiru. C. Srivatsan, Advocate for 4th opposite party and the 5th opposite party

has been set exparte and upon perusing the case records and hearing the arguments, and the case having stood over to this day for consideration, this Commission passed the following:

***ORDER***

***THIRU P.MARIMUTHU, MEMBER-I***

The complainant filed a complaint under Sec. 35 of Consumer Protection Act, 2019.

***The brief averments of the complaint are as follows:***

1. The complainant's wife namely Rajalakshmi on 8.1.2018 at 6.00 p.m. was riding a scooter when a street dog suddenly came across the road and Rajalakshmi fell down. She was taken to local hospital namely Kiruba Hospital and further treatment she was admitted in the G.Kupppusamy Naidu memorial Hospital, Coimbatore. The doctor found that the Rajalakshmi sustained injuries in her mouth part and face fracture neck Condylar process to mandible with dislocation noted on right side, undisplaced linear fracture in angle of right side of mandible extending to the socket of last molar tooth. Opinion was obtained from 4th opposite party being the Facio Maxillary surgeon suggested open reduction and internal fixation (ORIF) for putting pieces of broken bone into place by screws to hold the broken bone together and intermaxillary fixation. The complainant advised by 4th opposite party to admit complainant's wife in 3rd opposite parties hospital namely Kalpana Medical Centre (P) Ltd, Coimbatore for ORIF surgery on his care and gave reference letter to admit the complainant's wife Rajalakshmi to 3rd opposite party's hospital and also additionally mentioned it as the complainant's wife blood Hemoglobin count HB was 6% for necessary further steps to ensure surgery: Based on 4th opposite party's reference letter the complainant's wife was admitted to 11.1.2018 at about 4 p.m. The next day on 12.01.2018 was fixed for conducting surgery. As per the case sheet on 11.01.2018 at about 6.35 p.m hospital staff as per advise of 2nd opposite party and 4th opposite party, the hospital staff arranged two packed 'O' Positive red blood cells for blood transfusion purpose from the 5th opposite party's blood blank namely Swaasam blood bank, Avarampalayam, Coimbatore.

The nurse herself started blood transfusion, at 11 pm with given Lasix ½ injunction. But the complainant's wife Rajalakshmi felt body pain and leg pain and informed the duty nurse. But it was not attended to by any doctor. Finally at about 11.45 p.m. blood transfusion stopped. The patient Rajalakshmi continuously informed 3rd opposite party about her body pain and restlessness and other complications after blood transfusion. But neither hospital authority nor nurses seriously viewed the patient's problem. As per case sheet after blood transfusion stopped about 12.45 a.m. After the same the 1st opposite party came to hospital and informed 2nd and 4th opposite party through phone. Then after getting the advice from 2nd opposite party, 1st opposite party gave Injection Tramotol I Stat, injunction, emset 4 mg IV stat, Inj. Midaz 2 mg IV stat for pain relief and sleeping purpose At about 3.00 am on 12.01.2018 the patient was suffering heavy fever 105'F and chills. The patient's condition was informed to 2nd and 4th opposite party by 1st opposite party through phone. Following this 1 Pt NS rushed inj, avil 1 CC, Show I inj Efcorlin 100 mg IV Stat, Paracip infusion 100 ml -were administered. Opposite parties No. 1 to 4 were neither gave any emergency medical aid nor shifted Rajalakshmi to any multi-specialty hospital Again at 4.45 am suffered abdominal pain and complained the same to 1st opposite party and 2nd opposite party. Following this pan 40 mg (Pantoprazole - to decrease) the amount of acid produced in the stomach) and surfil syrup were administered. On 12.01.2013 at 6.20 a.m. the patient felt heavy drowsy and was in a state of semi consciousness which was informed to the 1st opposite party. At 6.30 a.m shifted the patient to the intensive care unit where IVF 10 Ns rushed, oxygen and Atropine, Inj - Adrenalina injected, CPR started subsequently at 6.50 a.m again gave above stated injection and the same was informed to 4th opposite party. But Rajalakshmi never recovered and at 7.00 am she was declared dead and the same was informed to 2nd and 4th opposite party. On 12.01.2018, at about 7.10 am 1st opposite party and 2nd opposite party issued medical certificate in which stated the cause of death as "Sudden Cardio respiratory arrest". Following this, the complainant lodged police complaint. The postmortem was conducted by associate professor H.Q.D of forensic medicine Coimbatore Medical College hospital and he gave his final opinion dated 13.01.2018 in

which stated Rajalakshmi death due to transfusion related acute lung injury(TRALI) caused by blood transfusion done for purpose of surgical repair of fractured mandible from 11.01.2018 - 11.00 p.m to 12.01.2018 - 6.30 a.m, the whole act of 1st opposite party to 4th opposite parties utter gross negligence, carelessness and recklessness etc., All never followed the standard mentioned procedure for transfusion practices before and after blood transfusion and did not take steps to resolve the complication immediately to save the life of said patient. Opposite parties must have checked the blood samples and the same should have been sent for laboratory investigation. 2nd and 4th opposite parties not directly attended the patient whole night to diagnose the patient. Opposite parties No. 1 to 4 failed to refer to any specialist who have expertise in blood transfusion or to any other multi-specialty hospital for treating the critical complications and for high risk management. The opposite Parties No. 1 to 4 failed to give her due care before, during and after blood transfusion process and no transfusion medicine specialist doctors were summoned to attend the patient. The whole procedure of the blood transfusion was wrong and negligent one. All the doctors involved in this case did not adopt the right course of treatment with reasonable degree of care and skill for transfusion related acute lung injury (TRALI) etc., and management. The complainant's wife Rajalakshmi died due to negligence and carelessness of all opposite parties. Opposite part No. 5 didn't adopt the standard and guidelines given by ministry of health and welfare government of India and acted in negligent manner. The complainant gave complaint to the Coimbatore District, Collector in which the joint director of health and rural welfare Coimbatore conducted enquiry. Opposite parties No. 1, 3 gave false and evasive answers in the enquiry and produced fabricated records. The opposite parties committed medical negligence which led to the death of Rajalakshmi Because of the death of Complainant's wife the future of complainant and his only son now studying in school have become gloomy and has caused heavy damage, immense loss and intolerable mental agony to them. The complainant prays that this Hon'ble court may be pleased to

a. direct the opposite parties No. 1 to 5 to pay Rs.50,00,000/- as compensation with interest for loss and mental agony occurred due to medical negligence and deficiency of service to the complainant

b. To pay the cost of the complainant.

***The brief averment of the written version filed by the 1st opposite party is as follows:-***

2. The complainant submitted a complaint to the District Collector of Coimbatore who instructed the Joint Director of Medical and Health Services Department to conduct enquiry. The Joint Director after conducting enquiry with the complainant and the opposite parties has filed a report stating that the complainant's wife died due to Transfusion-Related Acute Lung Injury and rejected the petition. Thereafter the complainant sent a legal notice and OP1 to OP4 sent a reply on 13.2.2020. The complainant on his own opted to admit his wife at OP3 hospital and hence OP4 issued a reference letter and he did not give any assurance that the complainant's wife would be completely cured. On 11.01.2018 at 6.35 PM ,OP3 hospital staff arranged two units of packed O positive blood from OP5 Blood Bank as per the advice of OP2 and OP4. The blood transfusion started on 11.1.2018 at 11.00 PM and administered 1/2 cc lesix injection. Total blood was not given to the complainant's wife. Since she had body pain and leg pain at 11.30 PM, the transfusion was stopped and she was found restless. Her SpO2 was 85%, pulse 20, BP 80/50 mm Hg .OP1 examined her and she was closely monitored. OP1 states that when he examined her at 12:30 and 12:45 AM, SpO2 was 75% to 85%, pulse rate was 64 to 78, and BP was 100/60. She was given oxygen continuously, and he recorded the details in the case sheet. When he examined the the complainant's wife at 1:15 AM, BP was 130/70, SpO2 was 96-98%, pulse was 88-107, and she was in deep sleep at 2:00 AM, as per the entries in the case sheet. On the advice of doctors, she was given symptomatic treatment. When informed at 3:00 AM that the complainant's wife had high fever of 105°F and BP 120/70, he examined her and sought advice from OP2. As per the advice of OP2, he administered an injection of para infusion 100 ml, injection Avil, ice packs, Efcorlin 100 ml, and normal saline IV fluid. All

these details are recorded in the case sheet. OP3 Hospital and doctors provided proper treatment to her in the whole night. The complainant's wife complained of severe abdominal pain at 4:45 AM, and as per the advice of the doctors, Pan 40 mg and Sucralfil syrup were given. When it was reported that the complainant's wife was unconscious state at 6:20 AM, OP1 immediately at 6. 30 AM gave intensive treatment and CPR. However, she passed away on 12.1.2018 at 7:00 AM, and it was informed to OP4 and other doctors. OP1 further states that following death intimation, since it was a road accident case, Police department took the body for postmortem to CMCH. In the postmortem report dated 13.01.2018 it is stated that the death was due to TRALI. The complainant's wife was given proper treatment and the allegation that due to negligence, substandard treatment given by OPs the complications occurred is stoutly denied. When TRALI condition happened to the complainant's wife, OPs gave proper treatment as stated medical literature. Before starting the O positive packed cell transfusion apart from obtaining written consent, all the tests were done and hence no breach of duty as alleged. Since the complication to the complainant's wife did not occur due to negligence of OPs, the complainant cannot claim damage while duty. The patient had an immune-mediated process that could not be identified before the transfusion. Despite the best treatment given, the complainant's wife suffered a medical accident and unfortunately passed away. The complainant, not having proper understanding and medical knowledge about the treatment given is making allegation against the OPs. Further, OP1 sates that for 80-85% of patients, antibodies are produced due to immune mediation, sometimes occurring in individuals with more than one pregnancy. When such blood is transfused, it can lead to TRALI (Transfusion-Related Acute Lung Injury). TRALI can also occur in those with lung diseases. Non-immune mechanisms can also trigger TRALI in some cases. The TRALI incident during the packed cell transfusion was not due to the OPs' negligence, as proper treatment was provided according to medical standards. OP1 and OP4 who treated the complainant's wife obtained medical degrees from Medical Colleges recognized by Medical Council and have treated patients like the complainant's wife. The problem that the complainant's wife experienced during blood transfusion was not due to

their negligence. Blood transfusion was given to the complainant's wife as per the procedure and she was treated properly after TRALI occurred. Despite this she had cardiorespiratory arrest and died. The complainant's wife was treated under the supervision of OP1. They gave treatment without any negligence and the allegation of carelessness is without any basis. The Joint Director after considering the documents and explanation given by OP1 to OP4 has rightly concluded that Tmt T. Rajalakshmi died due to TRALI and these kind of death happens one in 5000. The patient who had low blood level (6gms) and though proper treatment was given her body condition did not cooperate and she died. The Joint Director rejected the petition. The OPs gave proper treatment as per the medical procedure and there is no negligence. The OPs not liable to pay any compensation and hence the complaint is liable to be dismissed.

***The brief averment of the written version filed by the 2nd and 3rd opposite parties is as follows:-***

3. The contentions of the complainant are factually wrong, erroneous and medically misconceived and they are categorically denied. The complainant has made a speculative claim based on misconception. These Opposite parties submit that except as to those matters that are expressly admitted herein, these opposite parties puts the complainant to strict proof of the rest of the allegations made in the complainant. The complainant's wife namely one Rajalakshmi aged about 43 years who was said to be injured in a Road Traffic Accident on 8.1.2018 at 6.00 pm near Tahsildar office, Perur, and who was said to have been given first aid at Kiruba Hospital and later admitted in G.Kupppusamy Naidu Memorial Hospital, Coimbatore for further treatment was later admitted in the 3rd Opposite parties hospital based on the reference letter issued by the 4th Opposite party. The findings at G. Kuppusamy Naidu Memorial Hospital was that the complainant's wife (the patient) Rajalakshmi sustained following injuries in her "mouth part and face fracture neck Condylar process to mandible with dislocation noted on right side, un displaced linear fracture in angle of right side of mandible extending to the socket of last molar tooth". At G. Kuppusamy Naidu Memorial Hospital opinion was obtained from 4th opposite party being the

Facio Maxillary surgeon, for displaced fracture of right condyle of mandible, fracture right angle of mandible and it was suggested open reduction and internal fixation (ORIF) for putting pieces of broken bone into place by screws to hold the broken bone together and intermaxillary fixation. The 4th opposite party gave a referral letter to the 3rd opposite party. As the complainant's wife had only 6% of HB, the 4th opposite party had advised that she had to be cured and her HB normalized. This opposite party never gave any assurance that the patient would be completely cured and he never assured or advised the complainant or his wife to admit the patient at the 3rd opposite party's hospital. The complainant's wife was admitted in the 3rd opposite party's hospital on 11/01/2018 at 4pm and the surgery date was fixed on 12/01/2018. On 11/01/2018 at 6.35 pm, as per the instructions of the 4th opposite party, and 2nd opposite party, the 3rd opposite parties Hospital staffs got two bottles of packed O+ blood from Swasam Blood Bank the 5th opposite party herein and all the steps were taken to transfuse blood. On 11/01/2018 at 11 pm, we started only 0+ packed cell through IV and ½ cc Lasix injection was given that time, whole blood transfusion was not done. At 11.30 PM blood transfusion was stopped immediately since the complainant's wife developed leg pain and body pain. Immediately the 1st opposite party, Dr. Tamilselvan had checked the complainant's wife at 11.30 pm and found her SPo2 was 85%, BP was 80/50 mm of HG and it wrong to state that no doctors visited his wife. The 3rd opposite party took complete care of the complainant's wife as per the advice of Dr. Tamilselvan the 1st opposite party herein. The complainant's wife who was administered packed cell. As and when she complained of body pain and leg pain was checked by the 1st opposite party and treated by him and at 11.30 PM the packed cell administered to her was immediately stopped. The stoppage of transfusion was at 11.30 PM and not at 12.45 AM as claimed by the complainant and the development was informed to the 4th opposite party and the 4th opposite party discussed with the 1st opposite party. As per the advice the 1st opposite party she was given injection for pain and sleep. Once 0+ packed cell transfusion was stopped at 11.35 PM the 1st opposite party checked the complainant's wife and treatment was given continuously. when the 1st opposite party checked the complainant's wife at 12.30 PM and 12.45 PM her

pulse rate was 64 to 78 and BP was 130/70 and she was in deep sleep which are all found mentioned in case sheet. These opposite parties submit that symptomatic treatment was given to the complainant's wife as per the doctor's advice. Further at 3.00 AM early in the morning she had 99 degree fever and her BP was 120/70. On appraisal of the above information the 1st opposite party discussed with the 2nd opposite party immediately and injection Para infusion 100 ml through IV, injection Avil ICC slow through IV, Efcorlin 100 ml through IV, fluid normal saline through IV was given and the same is endorsed in the case sheet. It is incorrect to state that the 1st , 2nd and 4th opposite party and doctors of the 3rd opposite party hospital didn't give any proper treatment to the complainant's wife and they did not send her to multispecialty hospital for treatment and also they have not found out the cause of her condition. The opposite parties have provided appropriate treatment throughout the night early in the morning at 4.45 AM. The complainant's wife had severe pain and as per the doctor's advice Pan 40 mg and Sucril syrup was given. These opposite parties admit that on 12/01/2018 at 6.20 AM the complainant's wife had dizziness and the same was informed the 1st opposite party and immediately intensive treatment and CPR was given. However all efforts taken by the opposite party ended in vain and the complainant's wife died at 7.00 AM. On 12/1/18 death certificate was issued mentioning cardio respiratory arrest was the cause of death. The complainant had a given police compliant to take action against the opposite parties. The complainant's wife met with a road accident, and she admitted in our hospital with the complaints of jawbone fracture. Therefore road accident the death intimation had been given to police and they had taken the body to postmortem. After postmortem, the report which was given from Coimbatore Medical College Hospital on 13.01.2018 clearly mentioned that Rajalakshmi death was due to TRANSFUSION RELATED ACUTE LUNG INJURY (TRALI). These opposite parties categorically deny that from 11.01.2018 at 11.00 PM to 12.01.2018 to 6.30 AM the treatment which was given by them was careless, lethargic, and negligent and that blood transfusion was not done in the proper way and that during blood transfusion rules and terms were not followed. It is again herein reiterated that only packed cell was given and the allegations as leveled against these

opposite parties is due to the erroneous understanding of the medical practice and procedures and misunderstanding of what medical negligence is. Before surgery the 1st opposite party advised and instructed to start O+ packed cell, but then she had TRANSFUSION RELATED ACUTE LUNG INJURY. These opposite parties state as per the medical literatures they have given all the treatments and done their duty professionally and correctly. The allegations of breach of duty are ruled out, and as per the medical literatures the opposite parties have done our duty to the best of their conscience and professional ethics. Further before O+ packed cell was administered they have got written consent from the complainant to take all the tests and given appropriate treatment. Before packed cell transfusion was done, the patient had a problem which couldn't be identified. All of a sudden, the patient had a Medical Accident and it was the Immune Mediated Process that happened to her and the opposite parties did give their best treatment but however the patient had died. The complainant not having medical knowledge and unaware about transfusion related acute lung injury and the treatment was given to her is innocently complaining about the opposite parties. Therefore the complainant's claim that the opposite parties had not done their duty is erroneous and misconceived. Though it cannot be understood as to why a situation similar to that which happened to the complainant's wife takes place during blood transfusion as mentioned in the medical report, for 80 to 85% patients antibodies are produced due to Immune Mediation and it sometimes occurs to the persons who have given more birth or through child in womb. When this kind of blood that contains the above said Antibodies is transfused to others, it leads to a stage called TRALI. It is also mentioned in the medical literature that if such transfusion is done to person who already had undergone blood transfusion the situation of TRALI that happened to the complainant's wife may occur and if the person who is to be transfused blood has got lung diseases they might be affected by TRALl. It is also mentioned in the medical literature that per Non-immune mechanism, and when giving blood to some persons the situation TRALI may occur. It also happens when packed cell is transfused as in the case of the complainant's wife. It was a medical accident of Transfusion -related acute lung injury which take place when such type of

previously unidentified Packed Cell and blood transfusion was given and not due to lethargic and negligent act of the opposite parties. The 4th and 1st opposite parties have all obtained their medical degrees from medical colleges recognized by medical council. Therefore the complainant cannot claim that they are not qualified to treat her. The problem that the complainant's wife experienced during blood transfusion was not due to their negligence. Transfusion of Packed Cell was given to her as per the proper norms, and some hours when Transfusion -related acute lung injury situation occurred proper treatment was given but the complainant's wife suffered Cardio Respiratory arrest and she died due to it. Therefore it is wrong to allege that she had died due to improper treatment. It is further wrong to state that the doctors did not immediately find the problems caused by transfusion and did not take proper test before transfusion. The allegation that the complainant's wife was not sent to another hospital on time, and she has not gotten appropriate treatment while doing transfusion and after the transfusion as well is factually wrong and the complainant's wife before being administered Packed Cell and during the time she was given and after the same was administered was given treatment as per the standard norms and it is again wrong to allege that the complainant's wife was not treated under the supervision of the concerned doctors and the same is categorically denied by the opposite parties. The patient experienced Transfusion related acute lung injury, TRALI at the time of transmission and she suffered cardiac arrest which was not due to the negligence of the opposite parties and no wrong can be attributed to opposite parties as it is a situation where a complication occurs due to some other unidentified problems that pre-existed. The opposite parties had treated her properly as prescribed in the medical literature and they are there to save a life in any risky situation and they don't gain anything being negligent. She did not recover even after the intensive treatment given to her. These opposite parties submit that they did not give any wrong information or fake documents and if so the complainant is duty bound to prove the same with proper proof. They had properly treated the complainant's wife medically, scientifically, but in spite of the best efforts put by the opposite parties she developed Transfusion -related acute lung injury and suffered Cardio Respiratory arrest and she died

due to it. The loss of life of a patient is not only a loss to the family and her loved ones but also to the doctors, paramedical staff connected to the said hospital. The death of the complainant's wife was not caused by any negligent treatment. The claim of compensation of Rs.50,00,000/- from the Op's is a speculative claim based on misconception. The opposite party therefore prays that the complaint may be dismissed with cost.

***The brief averment of the written version filed by the 4th opposite party is as follows:-***

4. This Opposite Party submits that he is an unnecessary party to the proceedings. Except for referring the deceased Mrs.Rajalakshmi for admission to the 3rd Opposite Party hospital, this Opposite Party had no role to play in the treatment given to the patient. That being so, no negligence can be attributed to this Opposite Party. This Opposite Party is an oral and facio maxillary surgeon of repute who has been practicing in Coimbatore for the past 21 years. He is also a visiting surgeon in various multispecialty hospitals in Coimbatore including M/s G. Kuppusamy Naidu Memorial Hospital. The complainant's wife Mrs.Rajalakshmi was admitted in G. Kuppusamy Naidu Memorial Hospital Coimbatore on 09.01.2018 for treatment for the injuries sustained by her in a road accident which had occurred on 08.01.2018. Mrs Rajalakshmi had sustained grievous injuries including injuries in her mouth part and Face fracture neck condylar process to mandible with dislocation noted on right side, fracture in angle of right side of mandible extending to socket of last molar tooth. This Opposite Party was requested by M/s G. Kuppusamy Naidu Memorial Hospital to have a look at the above facial injuries sustained by Mrs. Rajalakshmi. Accordingly this Opposite Party attended on the injured and found that she had a displaced fracture of the right condoyle of mandible and right angle of mandible, which required surgery. This Opposite Party informed the injured as well as the complainant about the same. On the next day i.e. 10.01.2018, a few of the relatives of Mrs. Rajalakshmi came and met this Opposite Party in his hospital at Sai baba Colony, Coimbatore and wanted this Opposite Party to perform the surgery under the United India Insurance Company Government Insurance scheme. This Opposite Party informed them that he had no objection

to perform the surgery if the same was covered under insurance. However the relatives of Mrs.Rajalakshmi informed this Opposite Party that the said insurance was not accepted in G.Kuppusamy Naidu Memorial Hospital and requested this Opposite Party to suggest any other hospital where the above Insurance Scheme was accepted. Since this Opposite Party wanted to help the patient and her relatives, he referred the patient to the 3rd Opposite Party hospital, where the said insurance scheme was accepted. It was only under these circumstances that this Opposite Party has issued the referral letter dated 10.01.2018. It is pertinent to point out that even in the referral letter; this Opposite Party had clearly mentioned that the Hemoglobin level of the patient was only 6% which was very low and the same had to be increased if the surgery was to be performed by this Opposite Party. The patient was thereafter shifted to the 3rd Opposite Party hospital. On 11.01.2018 the complainant has executed the necessary consent letters for admitting his wife Mrs. Rajalakshmi in the 3rd Opposite Party hospital. After admission, the doctors in the 3rd Opposite Party hospital diagnosed that the patient was suffering from severe anemia. The blood reports were informed to the 2nd Opposite Party Dr. Antony who is an experienced physician. The 2nd Opposite Party immediately advised for 2 units of packed cells transfusion. 1 unit of packet cell transfusion was commenced with Lasix 1/2 CC injection at 11.00 PM on 11.01.2018. Since the patient complained of back pain, the packed cell transfusion was stopped at 11.45 PM. The condition of the patient was being continuously monitored by the 1st Opposite Party. At about 3 AM on 12.01.2018, this Opposite Party received a call from the 1st Opposite Party that the patient was experiencing high fever, chills and rigors. This Opposite Party immediately requested the 1st Opposite Party to get the advice of the 2nd Opposite Party who is the physician and the competent person to advise the proper course of treatment to be adopted. The 1st opposite party thereafter appears to have informed the 2nd Opposite Party about the condition of the patient and as per his advice, treatment was followed by the 1st Opposite Party. Thereafter, the condition of the patient improved and her fever subsided and her vitals became stable. On 12.01.2018 at about 06.40 AM he was informed by the 1st Opposite Party, that the patient had been shifted

to the ICU since there was a sudden deterioration in her condition and that she was not responding to treatment. This Opposite Party was further informed by the 1st Opposite Party that the patient had developed sudden cardio respiratory arrest and despite resuscitative measures taken by the attending doctors in the ICU, the patient could not be revived. The patient was subsequently declared dead on 12.01.2018 at about 07.10 AM. He had absolutely no role to play in the treatment given to the patient in the 3rd Opposite Party hospital. In so far as this Opposite Party is concerned, he had planned to perform the surgery on the patient after obtaining the necessary approval about her fitness from the physician. This Opposite Party is a dental surgeon and he did not advice or instructs the doctors in the 3rd Opposite Party hospital regarding the nature of treatment given to the patient. In fact the treatment given to the patient is outside the realm of expertise of this Opposite Party. The patient died despite the best treatment given to her by the doctors of the 3rd Opposite Party hospital. When, admittedly this Opposite Party has not given any treatment to the deceased, there can be no question of medical negligence that can be alleged as against this Opposite Party. Further the law is well settled that the onus of proving medical negligence is upon the person alleging the same. The complainant has not produced any proof in the form of expert medical opinion that the death of Mrs. Rajalakshmi was caused on account of negligence or improper treatment given by any of the Opposite Parties. The complainant should understand that every medical professional puts in his best efforts to save a patient and he does not gain anything by acting with negligence or by omitting to do an act. This Opposite Party did not advise the doctors in the 3rd Opposite Party hospital to administer blood transfusion for Mrs. Rajalakshmi and this Opposite Party, being a dental surgeon is not competent to advice the course treatment to be given to the patient for any other issue other than the field in which he is an expert. The normal accepted medical practice is that blood transfusion is to be given for increasing the hemoglobin level in any patient. It was this accepted procedure that was suggested by the 2nd Opposite Party, which cannot be found fault with. There is nothing on record to show that the blood transfusion procedure was substandard or that there was any negligence on the part of the

Opposite Party 1 and 2 in recommending and implementing the procedure. It defies logic that a doctor who has only referred a patient to a hospital and who is an expert in some other field of medicine should have personally attended to a patient, who was already under the care and supervision of other experienced and capable medical practitioners. There is an element of risk involved in every medical procedure which cannot be anticipated or prevented by any medical practitioner. Admittedly, the entire duration of treatment of Mrs. Rajalakshmi in the 3rd Opposite Party hospital was little over 12 hours only. In this short duration, all efforts were put in by Opposite Parties 1 to 3 to save the patient. It is pertinent to note that Mrs. Rajalakshmi was shifted to the 3rd Opposite Party hospital from G. Kuppusamy Naidu Memorial Hospital which is a multispecialty hospital for the sole reason that the complainant was not in a position to afford his wife's treatment in a multispecialty hospital and was dependent in the insurance cover covered under the United India (Government) Insurance scheme. Opposite Parties 1 and 2 are competent and experienced medical practitioners who are well versed in blood transfusion procedure. Therefore the question of summoning a transfusion specialist doctor does not arise. There is no negligence or deficiency in service on the part of this Opposite Party as falsely alleged. This Opposite Party is not liable to compensate the complainant with damages as sought for. The claim of Rs.50,00,000/- as compensation is unsustainable and without any basis and this Opposite Party is not liable to pay any amount to the complainant. This opposite party therefore prays that the Complaint may be dismissed with costs.

5. The complainant has filed his Proof Affidavit and Ex.A1 to Ex A12 have been marked. The 1st opposite party has filed his Proof Affidavit and Ex.B1 and Ex. B2 have been marked. The 2 to 4 opposite parties have filed their Proof Affidavit and no exhibits has been marked. The 5th opposite party has been set exparte.

***6. The points for consideration in this complaint are:***

1) Whether the allegation of negligence and deficiency in service against the opposite parties have been established?
2) What are the reliefs the complainant is entitled to?

## Point No.1:

7. The first and second opposite parties are Dr. R. Tamil Selvan and Dr. Antony, medical officers attached to Kalpana Medical Centre (P) Ltd, Coimbatore, the third opposite party herein. The fourth opposite party is Dr. Arunkumar of Maruti Dental and Face Surgical Centre, Coimbatore. The fifth opposite party is Swasam Blood Bank, Coimbatore.

**Brief Facts:**

8. The complainant's wife, Mrs. Rajalakshmi, met with an accident on 8.1.2018 while riding a two-wheeler and was admitted to GKNM Hospital on the same day after receiving first aid. The hospital identified that she had sustained a displaced fracture of the right condyle of the mandible and a fractured right angle of the mandible. OP4, a visiting doctor at GKNM Hospital, advised an Open Reduction and Internal Fixation (ORIF) surgery, a type of surgery used to stabilize and heal the broken bone.

9. On 10.1.2018, OP4 gave a referral letter to OP3 Hospital, indicating that the patient's hemoglobin level was only 6% and needed to be increased before performing the surgery. Consequently, the complainant's wife was shifted to OP3 Hospital on 11.1.2018, and the surgery was scheduled for 12.1.2018. OP3 Hospital staff obtained two bottles of packed O+ blood from OP5 Blood Bank. The packed cell blood transfusion commenced on 11.1.2018 at 11:00 PM.

10. Meanwhile, the complainant's wife (hereinafter referred to as the patient) developed transfusion reactions, and the transfusion was stopped. Unfortunately, the patient passed away on 12.1.2018 at 7:10 AM. The complainant has filed the present complaint alleging negligence and deficiency in service against the opposite parties, seeking compensation and the cost of the proceedings from them.

**Submissions of the Complainant:**

11. The complainant alleges that based on OP4's reference letter, she was admitted to OP3 hospital. Following the advice of OP2 and OP4, the staff of OP3 hospital arranged for blood from OP5. The nursing staff of OP3 hospital commenced the blood transfusion at 11:00 PM. The patient developed body and leg pain, which was reported to the nursing staff at 11:30 PM. Despite this, the doctors did not attend to the patient, and the blood transfusion was only stopped at 11:45 PM, after informing the hospital of the patient's body pain and breathlessness. The case sheet mentioned that the transfusion was stopped at 12:45 AM. OP1, who arrived at the hospital after the transfusion was stopped, informed OP2 and OP4 over the phone. OP1 administered injections and medicines for pain relief and sleep. At 3:00 AM, the patient had a high fever of 105°F and chills, which were reported over the phone to OP2 and OP4. OP1 administered injections and tablets as part of the ordinary course of treatment. However, the patient was neither given emergency treatment nor shifted to any multi-specialty hospital. The patient suffered severe abdominal pain at 4:45 AM. OP1 administered Pan 40 and Scurfil syrup to control the acid level in the stomach and for the treatment of ulcers. When the patient's condition became serious at 6:20 AM, OP1 shifted her to the ICU at 6:30 AM. However, she did not recover and was declared dead at 7:10 AM. OP1 and OP2 issued a medical certificate stating the cause of death as sudden cardiorespiratory arrest.

12. The complainant further argues that following his police complaint, a postmortem was conducted by CMCH, and Dr. Jeyasingh, Associate Professor and Head of the Department of Forensic Medicine, gave a final opinion stating "death due to Transfusion Related Acute Lung Injury caused by Blood Transfusion done for the purpose of surgical repair of fractured mandible."

13. The complainant further submits that OP1 to OP4 did not follow the standard medical procedures before, during, or after the blood transfusion and were negligent. OP1 to OP4 did not provide treatment for the complications of the blood transfusion reaction and failed to act immediately. Additionally, the OPs did not obtain

consent for the blood transfusion. They failed to bring in transfusion medicine specialist doctors to attend to the patient. The complainant asserts that if OP1 to OP4 had acted diligently according to the guidelines issued by the Government of India for blood transfusions, his wife would have survived. He claims that the negligence of OP1 to OP4 caused the death of his wife, and he is entitled to the reliefs sought.

**Submissions of OP 1:**

14. OP1 contends that based on the complainant's petition to the District Collector, Coimbatore alleging negligence against the OPs, the Joint Director of Medical and Health Services Department (hereinafter referred to as 'JD Health') conducted an inquiry and gave a report stating that the complainant's wife died due to Transfusion-Related Acute Lung Injury (TRALI) and rejected the petition. OP4 issued a reference letter to OP3 at the request of the complainant. On the advice of OP2 and OP4, the OP3 hospital staff arranged two units of packed O positive blood from OP5. The blood transfusion commenced on 11.1.2018 at 11:00 PM, and a Lasix (furosemide) injection, 1/2 cc, was administered. Since the patient complained of leg and body pain, the transfusion was stopped at 11:30 PM.

15. OP1 further argues that the complainant's wife was restless at the time and her SpO2 was 85%, with BP at 80/50 mm Hg. He examined her at 11:35 PM, and she was under continuous monitoring and his supervision, receiving necessary treatment. When he examined her at 12:30 and 12:45 AM, SpO2 was 75% to 85%, pulse rate was 64 to 78, and BP was 100/60. She was given oxygen, and he recorded the details in the case sheet. OP1 further submits that when he examined the patient at 1:15 AM, BP was 130/70, SpO2 was 96-98%, pulse was 88-107, and she was in deep sleep at 2:00 AM, which is also recorded in the case sheet. On the advice of doctors, she was given symptomatic treatment. When informed at 3:00 AM that the patient had a fever of 105°F and BP 120/70, he examined her and sought advice from OP2. As per the advice of OP2, he administered an injection of paracetamol infusion 100 ml, injection Avil, ice packs, Efcorlin 100 ml, and normal saline IV fluid. He recorded these details in the case sheet. The OPs provided proper treatment to the patient. The patient complained of severe abdominal pain at 4:45 AM, and

as per the advice of the doctors, Pan 40 mg and Sucralfil syrup were administered. When it was reported that the patient was unconscious at 6:30 AM, OP1 immediately provided intensive treatment and CPR. However, she passed away on 12.1.2018 at 7:00 AM, and it was informed to OP4 and other doctors.

16. OP1 further argues that the patient was treated diligently, and the O positive packed cell blood transfusion was commenced as per the advice of OP4 under his supervision. After the patient had TRALI OPs gave proper treatment as per the standard procedure prescribed in the medical literature. Before starting the transfusion necessary tests were done on the patient and consent was obtained from the patient and there was no breach of duty and hence no question of causing damage. The patient had an immune-mediated process that could not be identified before the transfusion. Despite the best treatment efforts, the patient suffered a medical accident and unfortunately passed away. The complainant, lacking proper understanding and medical knowledge about the treatment undertaken, has blamed the OPs.

17. OP1 further argues that for 80-85% of patients, antibodies are produced due to immune mediation, sometimes occurring in individuals with multiple pregnancies. When such blood is transfused, it can lead to TRALI (Transfusion-Related Acute Lung Injury). According to medical literature, TRALI can also occur in those with lung diseases and those who have previously received blood transfusions. Non-immune mechanisms can also trigger TRALI in some cases. The TRALI incident during the packed cell transfusion was not due to the OPs' negligence, as proper treatment was provided according to medical standards.

18. OP1 and OP4, who treated the complainant's wife, are qualified medical professionals. They have treated patients with similar conditions at other hospitals, utilizing their full medical knowledge and experience. The OPs cannot be accused of improper treatment. The cause of TRALI during the packed cell transfusion was not due to OPs' negligence or carelessness.OP1 claims the transfusion was conducted according to norms, and despite proper treatment, the complainant's wife suffered a cardio-respiratory arrest and

died. The patient was treated according to standard norms before, during, and after the transfusion under the supervision of the first respondent. The death was due to an unexpected cardio-respiratory arrest caused by TRALI, despite proper treatment.

19. The OPs did not treat the complainant's wife with indifference or negligence as alleged. Following a complaint to the District Collector of Coimbatore, an investigation by the Joint Director of Medical and Rural Welfare confirmed that the death was due to TRALI, a rare condition that occurs in 1 in 5000 cases. The patient, with predisposing conditions including very low hemoglobin (6 gms), died despite proper treatment. OP1 asserts that the complaint should be dismissed.

**Submissions of OP2 and OP 3:**

20. OP2 and OP3 argue that, at the request of the complainant, the complainant's wife, who had only 6% HB (normal HB level is 12%), was admitted to OP3 hospital. OP4 had advised taking the necessary steps to ensure her surgery and normalize her HB. On 11.01.2018 at 6:35 PM, as per the instructions of OP4 and OP2, the hospital staff obtained two bottles of packed O+ blood from OP5, and all steps were taken to transfuse the blood. At 11:00 PM, they started the O+ packed cell transfusion through IV, and a Lasix injection was given, but a whole blood transfusion was not done. At 11:45 PM, the blood transfusion was stopped immediately, not at 12:45 AM as claimed by the complainant, since the complainant's wife developed leg and body pain. Immediately, OP1 checked the patient at 11:30 PM and found her SPo2 was 85% and BP was 80/50 mm Hg. Therefore, it is incorrect to state that no doctors visited the patient. The OPs took complete care of the patient as per the advice of OP1, and her condition was continuously monitored.

21. When the patient complained of body and leg pain, she was assessed by OP1 and treated accordingly. At 11:45 PM, the packed cell transfusion was immediately stopped. These details were informed to OP4, who discussed with OP1, and as per his advice, the patient was given an injection for pain and sleep. It is submitted that once the O+ packed cell transfusion was stopped at 11:45 PM, OP1 checked the patient and provided continuous treatment. When OP1 checked the patient at 12:30 AM and 12:45 AM, her pulse

rate was 64 to 78, her BP was 130/70, and she was in a deep sleep, as noted in the case sheet. Thus, the patient was always under observation, and symptomatic treatment was given as per the doctor's advice.

22. At 3:00 AM, the patient had a fever of 99°F and BP of 120/70. OP1 apprised and discussed this with OP2, and immediately an injection of paracetamol infusion 100 ml, injection Avil, ice packs, Efcorlin 100 ml, and normal saline IV fluid were administered. These details are found in the case sheet. The OPs provided appropriate treatment throughout the night, which is evident from the records. At 4:45 AM, the patient had severe pain, and as per the doctor's advice, Pan 40 and Sucralfate syrup were given. On 12.01.2018 at 6:20 AM, the patient had dizziness, and it was informed to OP1. Immediately, intensive treatment and CPR were given, but the patient died at 7:00 AM. The OPs issued a death certificate mentioning the cause of death as sudden cardiorespiratory arrest. Since it was a case of a road accident, death intimation was given to the police, and a postmortem was conducted by CMCH. On 13.01.2018, CMCH gave a report stating that the death was due to TRALI.

23. OP2 and OP3 argue that the complainant's allegations stem from a misunderstanding of medical practices, procedures, and the concept of medical negligence. According to medical literature, they acted in good faith, adhering to their professional ethics and conscience. They obtained written consent from the complainant before conducting the packed cell transfusion and provided appropriate treatment. Despite their efforts, the patient suffered an immune-mediated medical incident that could not have been predicted, leading to their death.

24. OP2 and OP3 further argue that 80-85% of patients may produce antibodies due to immune mediation, particularly in individuals who have given birth or are pregnant. Transfusing such blood can result in TRALI (Transfusion-Related Acute Lung Injury). Medical literature indicates that TRALI can also occur in patients with lung diseases or those who have previously received blood transfusions. Non-immune mechanisms can

sometimes trigger TRALI. The incident during the packed cell transfusion was not due to negligence, as they provided treatment according to medical standards.

25. OP1 and OP4, the treating physicians, are qualified medical professionals with experience treating similar conditions. They have treated patients with similar conditions at other hospitals, utilizing their full medical knowledge and experience.They cannot be accused of improper treatment. When TRALI occurred, they provided appropriate treatment, but the patient unfortunately died due to cardiorespiratory arrest. The TRALI was not caused by negligence or carelessness.

26. OP2 and OP3 state that the transfusion was conducted according to norms. Despite proper treatment, the petitioner's wife suffered a cardiorespiratory arrest and died. The patient was treated in line with standard norms before, during, and after the transfusion, under the supervision of the first respondent. The death, caused by TRALI, was unexpected and not due to negligence. The complainant has not produced any proof or expert medical opinion to show that negligence or improper treatment led to the death. The postmortem report confirms that the patient died due to TRALI.

27. The OPs did not treat the complainant's wife with indifference or negligence, as alleged. There was no unfair, negligent, or unethical practice, and they are not liable for compensation. The complaint is based on a mistaken belief, and OP2 and OP3 assert that it should be dismissed.

**Submissions of OP 4:**

28. OP4 argues that he was requested by GKNM Hospital to examine the facial injuries sustained by the complainant's wife. He found that she had a displaced fracture of the right condyle of the mandible and a fracture of the right angle of the mandible, which required surgery. On the next day, i.e., 10.01.2018, a few of Mrs. Rajalakshmi's relatives came to his hospital in Saibaba Colony, Coimbatore, and requested that the surgery be performed under the United India Insurance Company Government Insurance Scheme. He informed them that he had no objection to performing the surgery if it was covered under the insurance. However, the relatives of Mrs. Rajalakshmi stated that the

insurance was not accepted at GKNM Hospital and requested a suggestion for another hospital where the insurance scheme was accepted. Wanting to help the patient and her relatives, he referred the patient to OP3 Hospital, where the insurance scheme was accepted. It was under these circumstances that he issued the referral letter dated 10.01.2018. In the referral letter, he mentioned that the hemoglobin level of the patient was only 6%, which was very low, and needed to be increased for the surgery to be performed.

29. The patient was shifted to OP3 Hospital on 11.01.2018. The complainant executed the necessary consent letter for admitting his wife to OP3 Hospital. The doctors diagnosed that the patient was suffering from severe anemia. The blood reports were informed to OP2, an experienced physician. OP2 advised administering two units of packed cell transfusion. One unit of packed cell transfusion was commenced with Lasix 1/2 CC injection at 11:00 PM. Since the patient complained of back pain, the packed cell transfusion was stopped at 11:45 PM. The condition of the patient was continuously monitored by OP1. On 12.01.2018, at about 3:00 AM, OP1 informed him that the patient was experiencing high fever, chills, and rigors. He immediately requested OP1 to get the advice of OP2, who is the physician and the competent person to advise on the proper course of treatment. OP1 followed the treatment as per the advice of OP2. Thereafter, the condition of the patient improved, the fever subsided, and her vitals became stable.

30. OP4 asserts that on 12.01.2018 at about 06:40 AM, he was informed by OP1 that the patient had been shifted to the ICU due to a sudden deterioration in her condition. Despite resuscitative measures taken by the attending doctors in the ICU, the patient, who had developed sudden cardio-respiratory arrest, could not be revived and was declared dead at 07:10 AM on 12.01.2018. OP4 claims he had no role in the treatment given to the patient at OP3 hospital. As a dental surgeon, he had planned to perform surgery only after obtaining necessary approval about the patient’s fitness from the physician. He did not advise or instruct the doctors at OP3 regarding the treatment. The treatment given was outside his realm of expertise. OP4 maintains that the patient’s death, despite the best efforts of OP3 hospital doctors, cannot be attributed to any negligence on his part.

31. OP4 further argues that the burden of proving medical negligence lies with the complainant, who has not produced any expert medical opinion to support the claim. OP4 asserts that every medical professional aims to save a patient, and acting negligently offers no benefit to the practitioner. Therefore, the complainant must clearly establish a case of negligence.OP4 referred the patient to OP3 hospital solely to help with insurance coverage, which is now being misinterpreted as advising the complainant to admit his wife there. He did not advise the blood transfusion administered to the patient and, as a dental surgeon, is not competent to recommend treatment outside his field of expertise. The accepted medical practice of administering blood transfusion to increase hemoglobin was followed by OP2, and there is no evidence to suggest substandard procedure or negligence.

32. OP4 refutes the allegation that his failure to personally attend to the patient constitutes negligence, arguing that it is illogical to expect a specialist in a different field to attend to a patient already under the care of other capable practitioners. He emphasizes that there is inherent risk in every medical procedure and that the patient's treatment duration at OP3 was just over 12 hours, during which all efforts were made to save her. The patient was shifted from GKNM Hospital, a multispecialty hospital, to OP3 due to the complainant's financial constraints and reliance on insurance coverage. OP1 and OP2, being experienced in blood transfusion, did not need to summon a specialist.

33. OP4 asserts that there was no negligence or deficiency in service on his part and that the complaint should be dismissed.

**Analysis, Reasoning, and Conclusion:**

34. The oral arguments advanced by both parties have been heard, and the materials on record have been thoroughly examined. OP1, OP2, and OP3 contend that 80-85% of patients may produce antibodies due to immune mediation, particularly in individuals who have given birth or are pregnant. Transfusing such blood can result in TRALI (Transfusion-Related Acute Lung Injury). Medical literature indicates that TRALI can also occur in patients with lung diseases or those who have previously received blood

transfusions. Non-immune mechanisms can sometimes trigger TRALI. They further argue that the incident during the packed cell transfusion was not due to negligence.

35. OP1 produced medical literature on "Complications of Blood Transfusion," which indicates that immune-mediated TRALI occurs with an overall frequency of 1 in 5,000 transfused units, and non-immune TRALI with a frequency of 1 in 1,100. Dr. Jeyasingh, Associate Professor and Head of the Department of Forensic Medicine at CMCH, gave a final opinion (ExA10) stating, "death due to Transfusion-Related Acute Lung Injury caused by blood transfusion done for the purpose of surgical repair of fractured mandible." The Joint Director Health, in his report (ExA11), stated that TRALI occurs in 1 out of 5,000 transfusions and that the patient, having a very low hemoglobin level (Hb - 6g), died despite proper treatment.

36. Upon reviewing the medical literature produced by the complainant and OPs, it is observed that TRALI (Transfusion-Related Acute Lung Injury) is indeed caused by various factors and is considered a medical emergency. However, the question involved in the instant complaint is not the cause for TRALI and cause of death of the complainant's wife. Whether the opposite parties (OPs) followed the standard procedure before, during, and after the blood transfusion is the gravamen of the issue to be determined.

**Informed Consent:**

37. The complainant alleges that no informed consent was obtained for the blood transfusion . OP1, OP2 and OP3 assert that they got written consent from the complainant to take all the tests and had given appropriate treatment. OP4 also asserts that the complainant executed the necessary consent letter for admitting his wife to OP3 hospital. However, OP3 hospital, which claims to have obtained the consent letter, did not produce it. OP4 also did not provide any letter. There is no explanation for not providing the consent letter, much less an acceptable one. From this, it is evident that OP3 did not obtain the consent letter before transfusing blood.

38. It is pertinent to note that clause 11.1.1 of Chapter 11 "Bed-Side Transfusion Practices" of Standards for Blood Banks and Blood Transfusion Services

published by the National AIDS Control Organization, Ministry of Health and Family Welfare, New Delhi reads as follows:

"11.1.1 INFORMED CONSENT

39. The patient shall be informed about his/her need for blood, alternatives available, as well as risks involved in transfusion and non-transfusion, and document the same in the medical record that it has been done. His/her written consent shall be taken in the language he/she understands best only after providing information. For minors and unconscious patients, the parents or legal guardians or next of kin should sign the informed consent.

11.1.2 One-time consent for repeated transfusion may be permitted for a single admission.

11.1.3 The patient shall be provided with the opportunity to ask questions and has the right to accept or refuse transfusion."

OPs did not obtain consent, much less informed consent, before the blood transfusion, which is in contravention of the standard procedure as mentioned above.

40. The Hon'ble Supreme Court in Samira Kohli v. Dr. Prabha Manchanda has held that consent in the context of a doctor-patient relationship means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical, or therapeutic procedure. What is relevant and important is the inviolable nature of the patient's right regarding his body and his right to decide whether he should undergo a particular treatment or surgery. The nature of the information required to be furnished by a doctor to secure valid or real consent is crucial. The Hon'ble Supreme Court in the case of M. Chinniyan v. Sri Gokulam Hospital cited by the complainant elaborated on the importance of obtaining informed consent. In the present case, there is no informed consent before the blood transfusion, and it amounts to a deficiency in service and negligence by OP1 to OP3.

**Pre-Transfusion Tests:**

41. The complainant alleges that no tests were done before the blood transfusion. On the other hand, OP1 to OP3 argue that all the required tests were done and

the details are entered in the medical records. It is standard medical procedure to avoid a transfusion reaction, donated blood must be compatible with the blood of the patient who is receiving the transfusion.

42. Before a blood transfusion, two blood tests known as "type and cross match" are done. A "cross match" is performed to ensure that the donor red blood cells (RBCs) are compatible with the recipient's serum. To perform a cross match, a small amount of the recipient's serum is mixed with a small amount of the donor's RBCs. The mixture is then examined under a microscope to check for agglutination or hemolysis.

43. Upon examining the Doctor's Note (ExA3), it is noted that Dr. Vignesh observed on 11.1.2018 at 6:35 PM that blood reports were informed to Dr. Antony. The order was given to arrange 2 O+ packed cells. At 11:00 PM, Dr. Tamilselvan noted "advised to start packed cell 1 O+." Further, in the Nurses Chart (ExA9), it is noted on 11.1.2018 at 6:15 PM that "CBC should be checked," at 9:00 PM, "CBC reports informed to Dr. Antony," at 9:30 PM "2 O+ PC arranged," and at 11:00 PM "PC started, injection 1/2cc given."

44. From ExA3 and ExA9, it is revealed that there are no details regarding the conduct of compatibility tests and cross matches performed. The OPs did not submit any material to suggest that they performed these tests. Therefore, their failure to conduct these prescribed pre-transfusion tests is considered negligence and a deficiency in service.

**During Blood Transfusion:**

45. Admittedly, the complainant's wife was administered a packed cell O+ blood transfusion on 11.01.2018 at 11:00 PM at OP3 Hospital. According to the discharge summary from OP3 Hospital (ExA7) and the Doctor's Note (ExA3), it is noted that the transfusion was stopped at 11:45 PM. Upon reviewing the Nurses' Chart (ExA9), it is indicated that at 11:30 PM, the patient experienced body pain, leg pain, and breathlessness, with SpO2 levels ranging from 75% to 85% and blood pressure at 80/50 mm Hg. At 11:35 PM, the patient's condition was reported to Dr. Tamilselvan, who instructed to stop the transfusion and monitor the patient. At 11:45 PM, Dr. Tamilselvan ordered the transfusion to be stopped.

46. Further, it is noted from the Doctor's Note (ExA3) that on 12.01.2018 at 12:45 AM, Dr. Tamilselvan recorded that the patient was reviewed and was complaining of severe body pain. Dr. Tamilselvan informed Dr. Arunkumar MDS via phone, who advised injection Tramadol among other treatments. At 3:00 AM, Dr. Tamilselvan recorded that the patient was experiencing chills, rigors, and a fever of 105°F. Dr. Tamilselvan informed Dr. Arunkumar MDS via phone again and noted the patient was conscious, oriented, febrile, with a blood pressure of 90/60 mm Hg. At 6:35 AM, Dr. Tamilselvan recorded that the patient was received in the ICU with an SpO2 of 65%. At 6:48 AM, the patient went into cardiorespiratory arrest.

47. The Nurses' Chart (ExA9) indicates that on 12.01.2018 at 12:30 AM, the patient complained of body pain and severe back pain, with SpO2 levels at 75% to 85%, pulse rate at 64-78 bpm, and blood pressure at 100/60 mm Hg. This was reported to Dr. Tamilselvan, who informed Dr. Arunkumar and ordered injections of Tramadol, Emeset, Midazolam, and O2 support. At 1:00 AM, the patient's condition was informed to Dr. Antony, and the patient received 10 units of normal saline. At 1:15 AM, 2:00 AM, and 2:30 AM, it was reported that the patient was stable. At 2:50 AM, the patient had a fever of 105°F with rigor and chills, which was reported to Dr. Tamilselvan. At 3:00 AM, Dr. Tamilselvan advised an injection of paracetamol infusion 100 ml, injection Avil, ice packs, Efcorlin 100 ml, and normal saline IV fluid. The patient was monitored at 3:15 AM, 3:30 AM, and 4:00 AM. At 4:50 AM, the patient had severe abdominal pain, which was reported to Dr. Tamilselvan, who ordered injection Pan 40 and Scurfil syrup, and to continue monitoring the patient. At 5:45 AM, vitals were checked and recorded. At 6:20 AM, the patient was drowsy, which was reported to Dr. Tamilselvan. At 6:30 AM, Dr. Tamilselvan advised that the patient be shifted to the ICU. At 6:40 AM, Dr. Tamilselvan informed Dr. Arunkumar, and injections of Atropine and Adrenaline were given, followed by CPR. At 7:00 AM, the patient was declared deceased, and Dr. Arunkumar and Dr. BC were informed.

48. Based on the narration in paragraphs 45, 46, and 47, it is evident that despite the patient's complaints of body and leg pain at 11:30 PM, the transfusion was not

discontinued until 11:45 PM. Referring to the evidence of Dr. K. C. Usha, the Professor and Head of Transfusion Medicine at Medical College Hospital, Thiruvananthapuram, as cited by the Hon'ble NCDRC in the case of Samad Hospital Vs. Muhammed Basheer, decided on 25.5.2022, Dr. Usha stated that" transfusion must be immediately halted if a blood transfusion reaction occurs, and proper resuscitation to save the patient's life is necessary. A blood sample from the vein of the opposite limb should be sent for further investigation, and urine should be collected to check for hemolysis. These samples, along with the blood bag containing the remaining blood, should be sent to the same blood bank for hemolysis testing. Urine tests for hemoglobinuria are often transient. It was also the bounden duty of the doctors at OP-1 hospital to preserve the remaining blood in the blood bag". The OPs did not provide any material to substantiate that they acted according to the guidelines outlined by Dr. Usha after the transfusion reaction. Even the medical literature produced by the OPs suggests that transfusion reactions should be managed as per the aforementioned medical practice. The Hon'ble NCDRC in the Samad Hospital case (supra) has observed that haemovigilance is the ‘systematic surveillance of adverse reactions and adverse events related to transfusion’ with the aim of improving transfusion safety. Transfusion reactions and adverse events should be investigated by the clinical team and hospital transfusion team and reviewed by the hospital transfusion committee. There is no material available to suggest that the above procedures were followed. Therefore, the contention of OP1 to OP4 that they provided appropriate and proper treatment by following the standard medical procedure is untenable. Consequently, the Commission finds that OP1 to OP4 committed a breach of duty while treating the complainant's wife after she complained of a blood transfusion reaction.

**Liability:**

49. a) Dr. Tamilselvan (OP1) was the duty doctor during the transfusion. From the Doctor's Note (ExA3) and the Nurses' Chart (ExA9), it is noted that Dr. Antony (OP2) was consulted before the transfusion. OP2 and OP3 also stated that, as per the

advice of OP2 and OP4, OP3 hospital staff arranged two units of packed O positive blood from OP5. During the transfusion, at 1:00 AM, Dr. Antony was consulted again.

50. OP4 argues that OP2 advised administering two units of packed cell transfusion. On 12.01.2018, at about 3:00 AM, OP1 informed OP4 that the patient was experiencing high fever, chills, and rigors. OP4 immediately requested OP1 to seek the advice of OP2, who is the physician and the competent person to advise on the proper course of treatment. OP4 further asserts that on 12.01.2018, at about 6:40 AM, he was informed by OP1 that the patient had been shifted to the ICU due to a sudden deterioration in her condition. However, it is noted from the Doctor's Note (ExA3) that on 12.01.2018, at 12:45 AM, Dr. Tamilselvan recorded that the patient was reviewed and was complaining of severe body pain. Dr. Tamilselvan informed Dr. Arunkumar MDS via phone, who advised injection Tramadol among other treatments. Furthermore, in the discharge summary (ExA7), it is indicated that as per the orders of the admitting doctor Dr Arunkumar MDS (Dental and Fasciomaxilalry Surgeon) inj Tramadol, inj Emeset, inj Midaz 2 mg IV given. Therefore, the argument of OP4 that he did not advise or instruct the doctors at OP3 regarding the treatment and that it is illogical to expect a specialist in a different field to attend to a patient already under the care of other capable practitioners is not acceptable in view of the entries in the Nurses' Chart and the discharge summary. As a result of the above discussion, OP4 cannot avoid liability. OP3 hospital is vicariously liable. Given the facts and circumstances of the case, liability cannot be surgically dissected and individual liability cannot be assigned. OP1 to OP4 are jointly and severally liable.

**Expert opinion:**

51. OP4 further argues that the burden of proving medical negligence lies with the complainant, who has not produced any expert medical opinion to support the claim. The complainant asserts that he has discharged the initial burden of proving negligence and has produced sufficient material, including the final opinion of the Associate Professor of Forensic Medicine at CMCH (ExA10). Furthermore, the complainant cited the judgment of the Hon'ble Supreme Court in the case of CPL Ashish Kumar Chauhan vs. Commanding

Officer to show that, as per the principle of res ipsa loquitur, when the initial burden is discharged, the onus shifts to the OPs. In the present complaint, the complainant demonstrated that OP1 to OP4 did not follow standard medical procedures before and during the transfusion, thereby justifying the invocation of the principle of res ipsa loquitur. Therefore, it is for OP1 to OP4 to prove that they performed their duties without negligence, which they have failed to do. Consequently, the requirement for an expert medical opinion does not arise.

52. Further, OP4 cited the judgments of the Hon'ble Supreme Court in the cases of Dr. Chanda Rani Akhouri vs. Dr. Muthusethupathi and Kalyani Rajan vs. Indraprastha Apollo Hospital. In these judgments, the Hon'ble Supreme Court reiterated the settled position of law that medical professionals are not held liable for errors of judgment in choosing a course of treatment. However, the issue involved in the instant complaint relates to the allegation of failure to follow the standard medical procedure, and hence the judgments are not applicable.

53. Based on the above discussion, the Commission determines that negligence and deficiency in service have been proved against opposite parties 1 to 4. There is no allegation of negligence against the blood bank; hence, the complaint against OP5 is dismissed. Point No. 1 is answered in favour of the complainant.

**Point No.2:**

54. The Commission has found negligence and deficiency in service against OP1 to OP4, as detailed in Point No. 1. The next question to be determined is the quantum of compensation. The age of the complainant's wife was 43 years at the time of her death, and the complainant has to look after his school-going son.

55. In this connection, it is relevant to refer to the judgment of the Hon'ble Supreme Court in the case of Arun Kumar Manglik vs. Chiryu Health and Medicine Pvt. Ltd. (2019 7 SCC), wherein it was held as follows:

“ The complainant has lost his spouse, who was 56 years of age. Though she was not employed, it is now well settled by a catena of decisions of this Court that the contribution made by a non-working spouse to the welfare of the family has an economic equivalent”.

56. In Lata Wadhwa v. State of Bihar, a three-judge Bench of this Court computed damages to be paid to dependents of deceased persons as well as burn victims in the aftermath of a fire at the factory premises. The Court took into consideration the multifarious services rendered to the home by a home-maker and held the estimate arrived at Rs 12,000 per annum to be grossly low. It was enhanced to Rs 36,000 per annum for the age group of 34 to 59 years.

57. In Malay Kumar Ganguly v. Sukumar Mukherjee, Justice S. B. Sinha held thus:

“ 172: Loss of wife to a husband may always be truly compensated by way of monetary compensation. How one would do it has been baffling the court for a long time. For compensating a husband for loss of his wife, therefore, the courts consider the loss of income to the family. It may not be difficult to do when she had been earning. Even otherwise a wife's contribution to the family in terms of money can always be worked out. Every housewife makes a contribution to her family. It is capable of being measured in monetary terms although the emotional aspect of it cannot be. It depends upon her educational qualification, her own upbringing, status, husband's income, etc.’ Thus, in computing compensation payable on the death of a home-maker spouse who is not employed, the Court must bear in mind that the contribution is significant and capable of being measured in monetary terms.

54: In assessing the amount of compensation, we have been guided by the principle which has been laid down by the Constitution Bench in Lata Wadhwa and in National Insurance Company Ltd. v. Pranay Sethi with suitable modifications in a case involving medical negligence."

58. Furthermore, the Hon'ble NCDRC in the case of Samad Hospital (supra) has mentioned the factors to be considered while quantifying compensation.

59. Guided by the above judgment in like circumstances, the Commission is of the view that it is just, fair, and equitable to direct the opposite parties 1 to 4, who are jointly and severally liable, to pay Rs 20,00,000 (Rupees Twenty Lakhs only) as compensation to the complainant for the mental suffering and emotional trauma caused by their negligence and deficiency in service. Further, the opposite parties 1 to 4, who are jointly and severally liable, are directed to pay Rs 5,000 towards the cost of the proceedings. Point No. 2 is answered accordingly.

***60. In the result, this complaint is partly allowed directing the opposite parties 1 to 4 who are jointly and severally liable i) to pay a sum of Rs.20,00,000/- (Rupees Twenty Lakhs only) as compensation to the complainant for the mental suffering, emotional trauma caused by their negligence and deficiency in service, and ii) to pay a sum of Rs.5000/- (Rupees Five thousand only) towards the cost of proceedings. The above amounts to be paid within a period of one month from the date of this order failing which the opposite parties 1 to 4 shall be liable to pay interest at the rate of 9% p.a. towards the above said total amount till it is realized. The complaint as against the 5th opposite party is dismissed.***

Pronounced by us in Open Commission on this the 04th day of July, 2024.

| | | |
|---|---|---|
| **(Sd/-)** | **(Sd/-)** | **(Sd/-)** |
| (G.SUGUNA) | (P.MARIMUTHU) | (R.THANGAVEL) |
| Member | Member | President |

**List of Exhibits marked by the complainant:**

| | | |
|---|---|---|
| 1. | Ex. A1/ 11.01.2018 | Copy of the Discharge Summary |
| 2. | Ex. A2/ 11.01.2018 | Copy of the Reference letter from 4th opposite party |
| 3. | Ex. A3/ - | Copy of the Daily case note |
| 4. | Ex. A4/ - | Copy of the Nurse chart |
| 5. | Ex. A5/ - | Copy of the case sheet |
| 6. | Ex. A6/ 12.01.2018 | Copy of the Medical bill |

| | | |
|---|---|---|
| 7. | Ex. A7/ 12.01.2018 | Copy of the Discharge summary |
| 8. | Ex. A8/ 12.01.2018 | Copy of the FIR Cr.No 7/2018 |
| 9. | Ex. A9/ 13.01.2018 | Copy of the Post mortem report |
| 10. | Ex. A10/ 09.10.2018 | Copy of the Post mortem final opinion |
| 11. | Ex. A11/ 10.09.2019 | Copy of the Joint director health and rural welfare enquiry report |
| 12. | Ex. A12/ 02.01.2020 | Copy of the legal notice |

**List of witnesses examined on the side of complainant:**

| | | |
|---|---|---|
| 1. | PW1/ 14.02.2024 | Saipreman,S/o.Damodharan, Complainant |

**List of Exhibits marked on the side of 1st opposite party:-**

| | | |
|---|---|---|
| 1. | Ex. B1/ 26.04.2019 | Copy of the letter from Joint director health and rural welfare |
| 2. | Ex. B2/ 13.02.2020 | Copy of the reply notice |

**List of witnesses examined on the side of 1st opposite party:**

| | | |
|---|---|---|
| 1. | RW1/ 20.03.2024 | Tamil Selvan, Medical Officer, Opposite Party |

**List of witnesses examined on the side of 2nd & 3rd opposite parties:**

| | | |
|---|---|---|
| 1. | RW2/ 06.03.2024 | Bala Chandran, Managing Director , 2nd Opposite Party |

**List of witnesses examined on the side of 4th opposite party:**

| | | |
|---|---|---|
| 1. | RW3/ 20.03.2024 | Arun Kumar, Authorized Signatory, Opposite Party |

| | | |
|---|---|---|
| **(Sd/-)** | **(Sd/-)** | **(Sd/-)** |
| (G.SUGUNA) | (P.MARIMUTHU) | (R.THANGAVEL) |
| Member | Member | President |